FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041897

Facility Name: CARE CENTRE OF URBANA

Address: 907 NORTH LINCOLN (Number) URBANA (City) 61801 (Zip Code)

County: CHAMPAIGN

Telephone Number: (847) 674-4700 **Fax #** (847) 674-4733

IDPA ID Number: 36-4082501

Date of Initial License for Current Owners: 06/01/96

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: DON FIETS **Telephone Number:** (847) 674-4700 X40

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) BRADLEY ALTER

(Title) SECRETARY

Paid Preparer

(Signed) A _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) _____ Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number CARE CENTRE OF URBANA # 0041897 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,135	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			1,482	1,482	8
9	SNF/PED					9
10	ICF	22,553	1,750	459	24,762	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,553	1,750	1,941	26,244	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.63%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 06/01/96

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 06/01/96 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 12 and days of care provided 1,482

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number CARE CENTRE OF URBANA # 0041897 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	138,119	7,916	6,247	152,282		152,282		152,282			1
2	Food Purchase		111,900		111,900		111,900	(224)	111,676			2
3	Housekeeping	64,291	23,317		87,608		87,608		87,608			3
4	Laundry	34,796	11,009	364	46,169		46,169		46,169			4
5	Heat and Other Utilities			77,876	77,876		77,876	533	78,409			5
6	Maintenance	29,051	29,718	20,512	79,281		79,281	348	79,629			6
7	Other (specify):*			4,712	4,712		4,712		4,712			7
8	TOTAL General Services	266,257	183,860	109,711	559,828		559,828	657	560,485			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	922,302	63,434	76,276	1,062,012		1,062,012	21,914	1,083,926			10
10a	Therapy	8,823	271	717	9,811		9,811		9,811			10a
11	Activities	39,524	2,596	2,800	44,920		44,920		44,920			11
12	Social Services	37,796		1,240	39,036		39,036		39,036			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,008,445	66,301	90,033	1,164,779		1,164,779	21,914	1,186,693			16
	C. General Administration											
17	Administrative	36,148		23,904	60,052		60,052	6,423	66,475			17
18	Directors Fees											18
19	Professional Services			160,455	160,455		160,455	(97,079)	63,376			19
20	Dues, Fees, Subscriptions & Promotions			10,712	10,712		10,712	(1,773)	8,939			20
21	Clerical & General Office Expenses	68,755	13,952	166,485	249,192		249,192	(63,870)	185,322			21
22	Employee Benefits & Payroll Taxes			285,276	285,276		285,276	10,899	296,175			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,863	1,863		1,863	7,530	9,393			24
25	Other Admin. Staff Transportation			2,804	2,804		2,804	6,898	9,702			25
26	Insurance-Prop.Liab.Malpractice			69,415	69,415		69,415	11,598	81,013			26
27	Other (specify):* marketing	11,192			11,192		11,192	(11,192)				27
28	TOTAL General Administration	116,095	13,952	720,914	850,961		850,961	(130,566)	720,395			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,390,797	264,113	920,658	2,575,568		2,575,568	(107,995)	2,467,573			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: CARE CENTRE OF URBANA #0041897 **Report Period Beginning: 01/01/2005** **Ending: 12/31/2005**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	6,142	
	REPAIRS & MAINTENANCE		105	
			0	6,247
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		364	
			0	364
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		19,531	
	ELECTRICITY		46,053	
	WATER		12,292	
	CABLE TV - LOBBY		0	
			0	77,876
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		7,126	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		7,645	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		1,595	
	FIRE SERVICE		4,146	
			0	
			0	
			0	20,512
7	**OTHER**			
	SCAVENGER		4,712	
	SECURITY SERVICE		0	4,712
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	9,000	9,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	74,667	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,609	
	PHARMACY CONSULTANT	XVIII B 39-2	0	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	76,276
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	717	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	717
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		400	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,400	
			0	2,800
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	1,240	
			0	1,240
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number CARE CENTRE OF URBANA **#0041897** **Report Period Beginning: 01/01/2005** **Ending: 12/31/2005**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	23,904	23,904
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	6,699	
	ADMINISTRATIVE CONSULTANTS	XIX C	47,748	
	PROFESSIONAL FEES	XIX C	106,008	
			0	160,455
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	1,667	
	EMPLOYEE WANT ADS	XIX F	5,669	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	68	
	LICENSES & PERMITS	XIX F	3,150	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	158	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	10,712
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		0	
	EQUIPMENT REPAIR & MAINTENANCE		2,796	
	OUTSIDE CLERICAL SERVICES		119,496	
	PENALTIES / OVERDRAFT CHARGES	VI 18	31,508	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		177	
	TELEPHONE		10,398	
	MESSENGER SERVICE/postage		2,110	
			0	166,485

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	105,054	
	UNEMPLOYMENT COMPENSATION	XIX D	54,560	
	WORKERS COMPENSATION INSURANCI	XIX D	72,034	
	HOSPITALIZATION INSURANCE	XIX D	50,771	
	EMPLOYEE BENEFITS - OTHER	XIX D	986	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	1,871	
	CHICAGO HEAD TAX	XIX D	0	285,276
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	275	
	TRAVEL	XIX G	1,588	
			0	
			0	1,863
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		2,804	2,804
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		69,415	69,415
27	**OTHER**			
	BAD DEBTS	VI 24	0	
				0

GRAND TOTAL COLUMN 3 OTHER 920,658

CARE CENTRE OF URBANA
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2005

TOTAL FOOD PURCHASE	111,900	PATIENT MEALS	78732
LESS SALES TAX	(224)	ADD EMPLOYEE MEALS	0
NET FOOD	111,676	TOTAL MEALS/YEAR	78732
TOTAL PATIENT CENSUS	26,244	NET FOOD	111676
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	78732
TOTAL PATIENT MEALS	78732	COST PER MEAL	1.42
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number CARE CENTRE OF URBANA #0041897 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			23,467	23,467		23,467	9,301	32,768			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			39,511	39,511		39,511		39,511			32
33	Real Estate Taxes			47,013	47,013		47,013		47,013			33
34	Rent-Facility & Grounds				63,750		63,750	3,829	67,579			34
35	Rent-Equipment & Vehicles			4,193	4,193		4,193		4,193			35
36	Other (specify):* storage			982	982		982		982			36
37	TOTAL Ownership			115,166	178,916		178,916	13,130	192,046			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		50,692	78,936	129,628		129,628		129,628			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,203	54,203		54,203		54,203			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		50,692	133,139	183,831		183,831		183,831			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,390,797	314,805	1,168,963	2,938,315		2,938,315	(94,865)	2,843,450			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Facility Name & ID Number CARE CENTRE OF URBANA # 0041897 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	7,235	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(224)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(31,508)	21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(1,667)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(158)	20		28
29	Other-Attach Schedule	(64,092)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (90,414)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(4,451)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (4,451)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (94,865)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

CARE CENTRE OF URBANA

ID# 0041897

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 0	6	1
2	MARKETING SALARY	(11,192)	27	2
3	LEGAL FEES	(52,900)	19	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(64,092)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CARE CENTRE OF URBANA **#** 0041897 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(224)	0	0	0	0	0	0	0	0	0	0	(224)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	533	0	0	0	0	0	0	0	0	533	5
6	Maintenance	0	0	348	0	0	0	0	0	0	0	0	348	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(224)	0	881	0	0	0	0	0	0	0	0	657	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	21,914	0	0	0	0	0	0	0	0	21,914	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	21,914	0	0	0	0	0	0	0	0	21,914	16
	C. General Administration													
17	Administrative	0	(23,904)	30,327	0	0	0	0	0	0	0	0	6,423	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(52,900)	(47,748)	3,569	0	0	0	0	0	0	0	0	(97,079)	19
20	Fees, Subscriptions & Promotions	(1,825)	0	52	0	0	0	0	0	0	0	0	(1,773)	20
21	Clerical & General Office Expenses	(31,508)	(119,496)	87,134	0	0	0	0	0	0	0	0	(63,870)	21
22	Employee Benefits & Payroll Taxes	0	0	10,899	0	0	0	0	0	0	0	0	10,899	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	7,530	0	0	0	0	0	0	0	0	7,530	24
25	Other Admin. Staff Transportation	0	0	6,898	0	0	0	0	0	0	0	0	6,898	25
26	Insurance-Prop.Liab.Malpractice	0	0	11,598	0	0	0	0	0	0	0	0	11,598	26
27	Other (specify):*	(11,192)	0	0	0	0	0	0	0	0	0	0	(11,192)	27
28	**TOTAL General Administration**	(97,425)	(191,148)	158,007	0	0	0	0	0	0	0	0	(130,566)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(97,649)	(191,148)	180,802	0	0	0	0	0	0	0	0	(107,995)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CARE CENTRE OF URBANA # 0041897 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	7,235	0	2,066	0	0	0	0	0	0	0	0	9,301	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	3,829	0	0	0	0	0	0	0	0	3,829	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	7,235	0	5,895	0	0	0	0	0	0	0	0	13,130	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(90,414)	(191,148)	186,697	0	0	0	0	0	0	0	0	(94,865)	45

Facility Name & ID Number CARE CENTRE OF URBANA # 0041897 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE		CERTIFIED HEALTH MANAGEMENT	SKOKIE	BKKPG/MGMT

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 23,904			$	$ (23,904)	1
2	V	21	BOOKKEEPING	119,496				(119,496)	2
3	V	19	ADMIN CONSULTING FEES	47,748				(47,748)	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 191,148			$	$ * (191,148)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number CARE CENTRE OF URBANA # 0041897 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	CERTIFIED HEALTH MANAGEMENT		$ 0	$	15
16	V	5	ELECTRIC/GAS		" " "		533	533	16
17	V	6	MAINTENANCE		" " "		348	348	17
18	V	10	NURSING/MEDICAL RECORDS		" " "		21,914	21,914	18
19	V	17	ADMIN SALARIES		" " "		30,327	30,327	19
20	V	19	PROFESSIONAL FEES		" " "		3,569	3,569	20
21	V	20	FEES, SUBSCRIPTION		" " "		52	52	21
22	V	21	OFFICE EXP		" " "		87,134	87,134	22
23	V	22	EMPLOYEE BENEFITS		" " "		10,899	10,899	23
24	V	24	TRAVEL.SEMINAR		" " "		7,530	7,530	24
25	V	25	TRANSPORTATION		" " "		6,898	6,898	25
26	V	26	INSURANCE		" " "		11,598	11,598	26
27	V	30	DEPRECIATION		" " "		2,066	2,066	27
28	V	32	INTEREST		" " "		0		28
29	V	34	OFFICE RENT		" " "		3,829	3,829	29
30	V	35	EQUIPMENT RENTAL		" " "		0		30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 186,697	$ * 186,697	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CARE CENTRE OF URBANA # 0041897 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	BRADLEY ALTER		ADMINISTRATION		SEE ATTACHED SCHEDULE			SALARY	$ 20,487	17-3	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 20,487		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number CARE CENTRE OF URBANA # 0041897 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CERTIFIED HEALTH MANAGEMENT
Street Address: 3856 OAKTON SUITE 200
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: ((847) 674-4700
Fax Number: ((847) 674-4733

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	PER PATIENT DAY	246,749	8	$ 0	$	26,244	$ 0	1
2	5	ELECTRIC & GAS	" " "	246,749	8	5,007		26,244	533	2
3	6	MAINTENANCE	" " "	246,749	8	3,275		26,244	348	3
4	10	NURSING/MEDICAL RECORDS	" " "	246,749	8	206,038	206,038	26,244	21,914	4
5	17	ADMIN SALARIES	" " "	246,749	8	285,136	285,136	26,244	30,327	5
6	19	PROFESSIONAL FEES	" " "	246,749	8	33,552		26,244	3,569	6
7	20	FEE, SUBSCRIPTIONS	" " "	246,749	8	490		26,244	52	7
8	21	OFFICE EXP.	" " "	246,749	8	819,245	705,623	26,244	87,134	8
9	22	EMPLOYEE BENEFITS	" " "	246,749	8	102,474		26,244	10,899	9
10	24	TRAVEL/SEMINAR	" " "	246,749	8	70,798		26,244	7,530	10
11	25	TRANSPORTATION	" " "	246,749	8	64,859		26,244	6,898	11
12	26	INSURANCE	" " "	246,749	8	109,041		26,244	11,598	12
13	30	DEPRECIATION	" " "	246,749	8	19,425		26,244	2,066	13
14	32	INTEREST	" " "	246,749	8	0		26,244	0	14
15	34	OFFICE RENT	" " "	246,749	8	36,000		26,244	3,829	15
16	35	EQUIPMENT RENTAL	" " "	246,749	8	0		26,244	0	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,755,340	$ 1,196,797		$ 186,697	25

Facility Name & ID Number CARE CENTRE OF URBANA # 0041897 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	BankFinancial		x	working capital							23,096	6
7	BankFinancial		x	working capital line of credit							15,606	7
8	AICCO		x	ins. Financing							809	8
9	TOTAL Facility Related						$	$			$ 39,511	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 39,511	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number CARE CENTRE OF URBANA # 0041897 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	45,974	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	46,033	2
3. Under or (over) accrual (line 2 minus line 1).	$	59	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	46,954	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	47,013	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000	43,440	8
2001	44,633	9
2002	45,107	10
2003	45,072	11
2004	46,033	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 102% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2004 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CARE CENTRE OF URBANA COUNTY CHAMPAIGN

FACILITY IDPH LICENSE NUMBER 0041897

CONTACT PERSON REGARDING THIS REPORT DON FIETS

TELEPHONE (847) 674-4700 FAX #: (847) 674-4733

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	91-21-07-282-021	NURSING HOME	$ 46,033.12	$ 46,033.12
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 46,033.12	$ 46,033.12

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number CARE CENTRE OF URBANA # 0041897 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,000 B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number CARE CENTRE OF URBANA # 0041897 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	TILES,WALLPAPER,PAINTING,HANDRAILS			1997	30,742	789	39	788	(1)	6,795	9
10	REPAIR PARKING LOT			1997	5,347	356	15	356	0	3,030	10
11	ROOF EXHAUSTER, VENTILATION			1997	4,926	126	39	126	0	1,052	11
12	CEILING,DUCTWORK,DOOR			1998	10,864	279	39	279	(0)	2,114	12
13	TILE/INSTALLATION			1998	4,650	119	39	119	0	888	13
14	HVAC UNIT			1998	6,162	158	39	158		1,175	14
15	NURSES STATION REPAIR			1998	12,552	321	39	322	1	2,688	15
16	300 WING RENOVATION			1998	7,859	202	39	202	(0)	1,473	16
17	FIRE PROTECTION SYSTEM/DAMPERS			1999	37,334	957	39	957	0	5,885	17
18	LANDSCAPING/SIDEWALK			1999	17,035	437	39	437	(0)	2,687	18
19	WALL REPAIR/TILE/HANDRAIS/BUMPERS			2000	8,740	248	27.5	318	70	1,746	19
20	BASEBOARD HEAT			2000	2,306	123	27.5	84	(39)	515	20
21	NEW WATER SERVICE/WATER HEATER			2000	10,597	416	27.5	385	(31)	2,229	21
22	FIRE ALARM WORK			2000	9,647	351	27.5	351	(0)	2,005	22
23	ROOF REPAIR			2001	11,820	430	27.5	430	(0)	1,989	23
24	ROOF REPAIR			2001	3,056	111	27.5	111	0	476	24
25	WALL REPAIR AND TILE			2001	2,301	84	27.5	84	(0)	346	25
26	AIR CONDITIONERS			2002	11,670	425	27.5	424	(1)	1,484	26
27	DOORS-ALZ UNIT			2002	5,922	215	27.5	215	0	753	27
28	ALARMS SYSTEM			2002	1,982	72	27.5	72	0	252	28
29	WINDOW TREATMENTS			2003	1,851	289	5	370	81	1,388	29
30	KITCHEN SINK RELOCATION			2003	3,850	140	27.5	140		344	30
31	WALLCOVERING			2003	1,926	393	5	385	(8)	1,059	31
32	WALLCOVERING			2003	2,419	552	5	484	(68)	1,210	32
33	RES.PRIVACY TRACKS/INSTALL			2003	4,383	999	5	877	(122)	2,192	33
34	WALL A/C UNITS			2003	14,819	539	27.5	539	(0)	1,325	34
35	HEAT/COOL UNIT			2003	5,203	189	27.5	189	0	465	35
36	PANIC DEVICE			2003	1,440	52	27.5	52	0	151	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number CARE CENTRE OF URBANA # 0041897 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	FAN IN OXYGEN ROOM	2004	$ 1,168	$ 42	27.5	$ 42	$ 0	$ 84	37
38	DOOR	2004	1,715	62	27.5	62	0	124	38
39	WALL AIR CONDITIONERS	2004	7,434	270	27.5	270	0	540	39
40	REMOVE/INSTALL NEW WALLPAPER	2005	11,495	2,299	5	1,150	(1,150)	1,150	40
41	CONCRETE/ASHPALT REPLACEMENT	2005	7,520	167	15	251	84	251	41
42	LANDSCAPING	2005	5,700	190	15	190		190	42
43	ALARM/DOOR REPLACEMENT	2005	5,871	115	15	196	81	196	43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 282,306	$ 12,517		$ 11,416	$ (1,101)	$ 50,252	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CARE CENTRE OF URBANA # 0041897 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 108,929	$ 8,513	$ 18,155	$ 9,642	5-7 YRS	$ 106,047	71
72	Current Year Purchases	11,319	2,437	1,132	(1,305)	5 YRS	1,132	72
73	Fully Depreciated Assets	35,485					35,485	73
74			2,066	2,066				74
75	TOTALS	$ 155,733	$ 13,016	$ 21,353	$ 8,337		$ 142,664	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 438,039	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 25,533	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 32,768	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 7,235	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 192,915	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number CARE CENTRE OF URBANA # 0041897 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☒ YES ☐ NO
16. Rental Amount for movable equipment: $ 4,193 Description: SEE SCHEDULE ATTACHED
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number CARE CENTRE OF URBANA # 0041897 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number CARE CENTRE OF URBANA

STATE OF ILLINOIS
0041897 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 36,773	$		$ 36,773	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			11,425			11,425	2
3	Licensed Recreational Therapist	39-3	hrs							3
4	Licensed Physical Therapist	39-3	hrs			30,738			30,738	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				43,356		43,356	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	MEDICAL SUPPLIES & Other (specify): LABORATORY	39-2					7,336		7,336	13
14	TOTAL			$		$ 78,936	$ 50,692		$ 129,628	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number CARE CENTRE OF URBANA # 0041897 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 34,856)	419,894		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	26,239		6
7	Other Prepaid Expenses	5,831		7
8	Accounts Receivable (owners or related parties)	31,117		8
9	Other(specify): real estate escrow	24,919		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 508,000	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	282,303		15
16	Equipment, at Historical Cost	155,732		16
17	Accumulated Depreciation (book methods)	(189,324)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): option deposit	297,000		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 545,711	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,053,711	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,017,775	$	26
27	Officer's Accounts Payable	1,271,000		27
28	Accounts Payable-Patient Deposits	7,000		28
29	Short-Term Notes Payable	554,444		29
30	Accrued Salaries Payable	15,220		30
31	Accrued Taxes Payable (excluding real estate taxes)	13,369		31
32	Accrued Real Estate Taxes(Sch.IX-B)	46,954		32
33	Accrued Interest Payable	341,650		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,267,412	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	capital stock	10,000		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 10,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,277,412	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,223,701)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,053,711	$	48

***(See instructions.)**

Facility Name & ID Number CARE CENTRE OF URBANA **#** 0041897 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,326,615)	1
2	Restatements (describe):		2
3	balance correction from prior years	63,085	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,263,530)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	39,829	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 39,829	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,223,701)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number CARE CENTRE OF URBANA # 0041897 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,831,937	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,831,937	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	126,361	6
7	Oxygen	18,598	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 144,959	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	vending commissions	1,248	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,248	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,978,144	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	559,828	31
32	Health Care	1,164,779	32
33	General Administration	850,961	33
	B. Capital Expense		
34	Ownership	178,916	34
	C. Ancillary Expense		
35	Special Cost Centers	129,628	35
36	Provider Participation Fee	54,203	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,938,315	40
41	**Income before Income Taxes (line 30 minus line 40)****	39,829	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 39,829	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number CARE CENTRE OF URBANA # 0041897 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,431	1,451	$ 36,871	$ 25.41	1
2	Assistant Director of Nursing	2,811	2,878	58,394	20.29	2
3	Registered Nurses	3,583	3,703	89,963	24.29	3
4	Licensed Practical Nurses	9,936	10,150	197,826	19.49	4
5	CNAs & Orderlies	44,939	45,407	520,987	11.47	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	274	274	8,823	32.20	8
9	Activity Director	4,457	4,655	39,524	8.49	9
10	Activity Assistants					10
11	Social Service Workers	2,048	2,247	37,796	16.82	11
12	Dietician					12
13	Food Service Supervisor	1,977	2,080	39,481	18.98	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,110	4,287	38,688	9.02	15
16	Dishwashers	8,220	8,318	59,950	7.21	16
17	Maintenance Workers	2,143	2,159	29,051	13.46	17
18	Housekeepers	8,264	8,396	64,291	7.66	18
19	Laundry	4,591	4,780	34,796	7.28	19
20	Administrator	1,370	1,410	36,148	25.64	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,048	2,080	34,819	16.74	23
24	Clerical	3,502	3,658	33,936	9.28	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records		1,880	18,261	9.71	31
32	Other Health Care(specify)					32
33	Other(specify) marketing	865	865	11,192	12.94	33
34	TOTAL (lines 1 - 33)	106,569	110,678	$ 1,390,797 *	$ 12.57	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 6,142	1-3	35
36	Medical Director		9,000	9-3	36
37	Medical Records Consultant		1,609	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant		0	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		717	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant		2,400	11-3	44
45	Social Service Consultant		1,240	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 21,108		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	371	$ 17,427	10-3	50
51	Licensed Practical Nurses	1,496	57,240	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)	1,867	$ 74,667		53

Facility Name & ID Number CARE CENTRE OF URBANA # 0041897 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JOAN COOK	ADMIN		$ 28,973
BARBARA EILERS	ADMIN		7,175
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 36,148

B. Administrative - Other

Description	Amount
CERTIFIED HEALTH MGMT	$ 23,904
TOTAL (agree to Schedule V, line 17, col. 3)	$ 23,904
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		160,455
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 160,455

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 72,034
Unemployment Compensation Insurance		54,560
FICA Taxes		105,054
Employee Health Insurance		50,771
Employee Meals		0
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		986
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		1,871
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
MGMT CO ALLOCATION		10,899
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 296,175

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
NONE		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	5,669
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	1,825
TRUST/FRANCHISE/CONTRIB/ETC	0
LICENSES & PERMITS	3,150
DUES & SUBSCRIPTIONS	68
MGMT CO ALLOCATION	52
TRUST/FRANCHISE/CONTRIB/ETC	0
Less: Public Relations Expense	(0)
Non-allowable advertising	(1,667)
Yellow page advertising	(158)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,939

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	1,588
Seminar Expense	
	275
MGMT CO ALLOCATION	7,530
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,393

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number CARE CENTRE OF URBANA # 0041897 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	PAINT/DECORATING		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number CARE CENTRE OF URBANA # 0041897 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **54,203**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees